CY 2006 PART D REPORTING REQUIREMENTS: FREQUENTLY ASKED QUESTIONS

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General

Changes made since the first release of this FAQ in May 2006 are highlighted.

1) How are data listed in this document submitted to CMS?
   A: For the majority of the reporting requirements sections, Plans will enter data directly into Health Plan Management System (HPMS). Only the Rebate section will have an upload function available. In addition to entering data into HPMS for the Licensure and Solvency section, Plans will mail hard-copies of various documents to CMS. Please refer to the HPMS Part D Plan Reporting Requirements User's guide for more detailed information about data submission.

2) Where are the reporting modules located in HPMS?
   A: After log-in to HPMS, the users should:
   - Select *Quality and Performance, Part D Plan Reporting* from the left-hand menu on the HPMS Home page.
   - Select CY 2006.
   - At the *Part D Plan Reporting CY 2006 – Start Page*, choose the *Quarterly* option on the left of the screen.
   - Select contract ID and click *Next*.
   - Review the individuals listed in the Email notification list. Updates are made by accessing the User Account Maintenance Module or the Contract Management Module.
   - Each reporting requirement section is listed alphabetically. Under each section, the relevant collection periods, due dates and current status are displayed.
   - Select the reporting requirement section and the collection period.
   - Submit data according to the section's pre-formatted fields.

3) Are data to be reported at the Contract level or Plan level? Does Plan level mean at the PBP level?
   A: The level of reporting for each section is specified in the reporting requirements document and within the HPMS section. Contract level reporting indicates data should be entered at the H#, S# or R#. Plan level reporting indicates data should be entered at the PBP level, (e.g. Plan 001 for contract H#, R#, or S#). CMS has determined that plan-level reporting is necessary to conduct appropriate oversight and monitoring. Below is a summary of the level of reporting required for each section.

REPORTING REQUIREMENT SECTION	LEVEL OF REPORTING (Contract, Plan)

REPORTING REQUIREMENT SECTION	LEVEL OF REPORTING (Contract, Plan)
Enrollment/Disenrollment	Plan
Reversals	Plan
MTMP	Contract
Generic Dispensing Rate	Plan
Grievances	Plan
PA, Step, NF, Tier exceptions	Plan
Appeals	Plan
Call center	Contract or Plan
Overpayment	Plan
Rebates, Other price concessions	Contract
Licensure and Solvency, Business Transactions, and Financial requirements	Contract

Final reporting requirements for CY 2006 were first released by CMS in April 2005, following a period of public review and comment to draft requirements, and resulting revisions. During the public comment period, CMS received requests to clarify the level of reporting in various areas, but did not receive any comments that Plan level reporting was inappropriate. CMS believes ample time and notice were provided to all prospective plans (as Plans had not been approved by April 2005) for review of the reporting requirements in terms of content as well for individual programming changes necessary for compliance. Compliance to CMS reporting requirements is a contractual obligation of all Part D Sponsors, regardless of system changes required within the organization of the Plan or within their subcontracted PBM to meet these requirements.

4) Where is the reporting requirements document posted?
A: CY 2006 Part D Plan Reporting Requirements are posted at http://www.cms.hhs.gov/PrescriptionDrugCovContra/08_RxContracting_ReportingOversight.asp. CMS released the final document in April 2005, and made slight revisions in January 2006. The revisions made in January were the addition of a disenrollment category of "other", and the revision of licensure and solvency reporting timeframes to better match those followed by industry. It was anticipated that these changes would assist Plans in accurately reporting data to CMS.

Materials related to CY 2007 Part D Reporting requirements are also posted at this website.

5) As stated in the Reporting requirements document, Program for All inclusive Care for the Elderly (PACE) organizations are not required to submit data for all reporting sections. How should these organizations document when a specific section is not applicable to them?
A: For CY 2006, PACE organizations are limited to reporting data for the following sections: Enrollment/Disenrollment; Generic Dispensing Rate; Overpayment; Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions;

Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions (only for organizations utilizing formularies). Only these sections will be displayed to PACE organizations. If a reporting section does not apply to a PACE organization, the PACE organization should select the option, "No data to report". Zero values should not be entered.

6) Are MA-PD organizations required to comply with all reporting requirements?
A: All reporting requirements apply to MA-PD organizations with the exception of those found in Section XI. Licensure and Solvency, Business Transactions and Financial Requirements.

7) Are Employer groups required to comply with all reporting requirements?
A: PDPs and MAOs are required to comply with all of the Part D reporting requirements for all of their employer-only group waiver plans ("800-series"). None of the requirements for Part D reporting have been waived for these kinds of EGWPs. For EGWPs that are employer/union direct contract PDPs (Direct PDPs) some Part D reporting requirements have been waived or modified for 2006 and 2007. These entities should speak with their account manager for detailed information about which of these Part D reporting requirements have been waived and/or modified.

8) Are these reporting requirements applicable to MA Plans?
A: The Part D Plan reporting requirements apply to all plans offering the Part D benefit, including PDPs and MA-PDs. They do not apply to MA plans that do not offer a Part D benefit.

9) Where can Plans send questions about Part D reporting requirements?
A: Questions may be sent via email to partd-planreporting@cms.hhs.gov.

10) Should Part B drug claims always be excluded from these reports?
A: Yes, Plans should not include data relating to Part B claims in their Part D reporting.

11) Should enhanced alternative and OTC drug claims be included?
A: No, these claims are not paid as Part D claims, and should not be included in Plans' Part D reporting.

12) What are the implications for Part D Sponsors who are non-compliant to the reporting requirements?
A**:** Part D sponsors' compliance is a contractual obligation. Noncompliance may be considered as late or inaccurate submission of data, as well as submitting data at incorrect reporting levels. According to Subpart O, sanctions may be imposed on Part D Sponsors who fail to comply with these reporting requirements. Sponsors who fail to submit data may face corrective action plans.

13) Can Part D Sponsors correct submitted data after the reporting deadline?

A: Yes, Part D Sponsors must send an email to partd-planreporting@cms.hhs.gov requesting the opportunity to resubmit. Please indicate the contract #, plan #, reporting section, and reason for this request. CMS will respond to the request.

14) Does CMS expect Part D Sponsors to update previously submitted data?
A: If previously submitted data are incorrect, Part D Sponsors should request the opportunity to correct and resubmit data as described above. Please note: Plans are not responsible for updating previously submitted data reporting sections such as enrollment/disenrollment in which CMS expects Plans to receive retroactive data.

15) Within each reporting section, an option "No Data to Report" is displayed. When is it appropriate to select this option?
A: Those Part D sponsors who determine a reporting section is non-applicable to their organization may select "No Data to Report". For example, PACE organizations that do not utilize formularies may select "No Data to Report" for the Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions. Additionally, Part D sponsors with zero Part D enrollment during the reporting time-period may select "No Data to Report". "No Data to Report" is not equivalent to reporting zero values.

Section I. Enrollment/Disenrollment

1) For data element A, the number of beneficiaries enrolled in the Plan as of the end date of the reporting period, should Plans report the total number of beneficiaries or the total number of new enrollees?
   A: Data element A is intended to reflect a snapshot in time, and therefore Plans should report the total number of Part D beneficiaries enrolled as of the end date of the reporting period.

2) Should data element A include beneficiaries who enrolled but never reached their effective date of enrollment?
   A: No, these beneficiaries should not be included. Enrollment cancellations prior to the effective date should not be included. For example, beneficiaries who begin the enrollment process but withdraw, beneficiaries who are found to be ineligible, or otherwise cancel out prior to becoming effective should not be included in either enrollment or disenrollment data.

3) For data element B, number of beneficiaries who disenrolled for any reason from the Plan any time during the reporting period, should this include beneficiaries who were disenrolled in error and have been re-enrolled?
   A: Yes, these beneficiaries should be included in both data element B as well as data element H, number of disenrolled due to a reason other than listed subcategories if there was a gap in coverage. If the disenrollment and subsequent re-enrollment occurred within the same month it is not counted as a disenrollment.

4) Should data element B include only disenrollments received by the plan, or also disenrollments received through the reply listing (i.e. enrollment into another Part D plan)?
   A: Plans should report all disenrollments in data element B. Additionally, Plans should report those disenrollments received through the reply listing in data element H, number of disenrolled due to a reason other than listed subcategories since Plans will not be able to determine the specific causes of these disenrollments.

5) How should Plans report retroactive cancellations - e.g., a Plan receives an enrollment transaction for January and later receives an enrollment cancellation retroactively. Should this beneficiary be completely excluded, or should the beneficiary be counted as both an enrollment and a disenrollment?
   A: If the enrollment's effective date was never been reached, this should not be counted as either an enrollment or a disenrollment. If the enrollment's effective date has been reached, this should be counted as an enrollment and as a disenrollment.

6) How should Plans accurately report retroactivity as CMS can process retro-transactions up to 36 months?
   A: CMS does not expect Plans to update previously reported data with retroactive information. Enrollments or disenrollments should be reported in the reporting period

in which the effective date occurs. Plans should consider the last day of the reporting period as the cut-off date. For example, 3/31/06 is the last day of the reporting period for the first Quarter. Any retroactivity received after 3/31/06 that applies to Q1 should be reported in Q2.

- A Plan receives a confirmed enrollment on March 18 for a May 1 effective date. Due to the effective date of 5/1, the Plan should report this enrollment in Q2.

7) For data elements C-H, Plans must report the numbers of disenrolled beneficiaries for certain disenrollment reasons. Does CMS have standard disenrollment codes for the various disenrollment reasons identified in the report? Does CMS expect Plans to perform retroactive follow-up with previous disenrollees to identify their reason for voluntary disenrollment?
   A: The disenrollment categories are derived from MMA regulations. Total disenrollment is also collected. While CMS will not provide operational guidelines for how Plans should collect these data, it is requested that Plans provide disenrollment data by category to the best of their abilities. Most of the disenrollment codes used by the MARx system can be aggregated to fit 1 of the categories. Note that enrollment/disenrollment reporting requirement Item H, "# disenrolled due to other reason", should be utilized for those disenrollments that do not fit previously listed categories. CMS does not expect Plans to conduct retro follow-up in order to determine these reasons.

8) Which method should be used to report member disenrollment - last covered date or first non-covered date?
   A: Plans should use the last covered date.

9) If a beneficiary is disenrolled for non-payment of premium, appeals the disenrollment and has their coverage reinstated without a break in enrollment, should the member be reported as a disenrollment from the Plan?
   A: No, as there was not a break in service, this beneficiary should not be counted as a disenrollment.

10) What is the definition of a beneficiary disenrollment?
   A: A disenrollment occurs when a beneficiary whose enrollment has been deemed to be effective subsequently leaves the plan. The plan reports this disenrollment based on the beneficiary's last covered date.
   Example: A beneficiary's last covered date is 6/30/06. The plan should report this beneficiary as an enrollment in Q2, and a disenrollment in Q3.

Section II. Reversals

1) How does CMS define “out of cycle” pharmacy transactions?
A: The term "out-of-cycle" is referring to the individual billing/processing cycle of each organization. . Each organization determines its own payment cycle. An out of cycle reversal occurs if a prescription is filled and adjudicated, and then, outside the Plan’s billing cycle, the pharmacy reverses the claim because the prescription was not picked up. Plans must report to CMS the total number of (electronic, paper and manual) pharmacy claims ending with a reverse status. Those with partial reversal as the final disposition should also be included.

Out of cycle does not refer to the CMS quarterly reporting periods. The intent of this reporting section is to gain a cursory view of pharmacies' claim adjudication and reversal patterns to protect against fraudulent cash flow activities. At the same time, CMS is accommodating for the various billing cycles utilized by Part D plans.

Example: A Plan’s billing cycles are the 1st – 15th of the month and the 16th-end of month. The following transactions are examples when reporting out-of-cycle reversals:

Claim transaction	Out-of-cycle reversal or not?
1) Original claim processed on the 2nd, reversed on the 5th.	**Not a reversal**
2) Original claim processed on the 2nd, reversed on the 17th. No other transaction received before the end of the reporting quarter.	**Reversal**
3) Original claim processed on the 14th, reversed on the 16th. No other transaction received before the end of the reporting quarter.	**Reversal**
4) Original claim processed on the 2nd, reversed on the 17th. Resubmitted on 18th.	**Not a reversal**

2) The reporting requirements document states these records must be maintained and equivalent to the elements of the PDE record. Is there a specific field in mind for record keeping or nomenclature that is preferred?
A: At a minimum, the data elements required for the PDE should be kept for all reversed claims.

Section III. Generic Dispensing Rate (GDR)

1) Regarding the two data elements within this reporting section, please clarify the phrase, "regardless of days supply".
   - Data element A: Number of paid claims for generic drugs (regardless of days supply) with dates of service during the specified reporting period identified above.
   - Data element B: Total number of paid claims (regardless of days supply) with dates of service during the specified reporting period identified above.

   A: This statement indicates that each prescription fill should be counted as one fill, regardless of the prescription's days supply. This would mean a 30 day prescription counts as one, as does a 60 day prescription, and a 90 day prescription.

2) Should these data match Plans' PDE data submitted to CMS? If so, should Plans delay their reporting until they have received the PDE submission results?
   A: No, Plans should simply report summary pharmacy claims information for this reporting section, e.g. # of generic claims, and total # of claims. This should not be affected by Plans' submission of PDE data.

3) Should Plans report all claims, regardless if they have been reversed, or only net claims (excluding those claims that are reversed).
   A: Plans should not include reversed claims in either data element A (# of paid claims for generic drugs) or B (total # of paid claims).

Section IV. Medication Therapy Management Programs (MTMP)

1) What is the level of MTMP data to be reported – Contract level or Plan level?
   A: As of August 2006, CMS has changed the level of MTM reporting to be at Contract level. This change was due to the recognition that MTM data are more appropriately reported at the Part D contract level since that is the level at which MTM programs were approved. HPMS changes necessary to accommodate this change in the level of MTM reporting will be completed by October 2006. Therefore, for the first MTM reporting deadline of August 31, 2006, Part D Sponsors should input their contract level MTM data within the first PBP listed under their contract number, and select "No Data to Report" for all other PBP fields. CMS hopes this change will better reflect plan sponsors' MTMP operations.

2) Example scenario: A beneficiary is enrolled in Plan 1, meets the MTM eligibility criteria, but disenrolls from Plan 1 to enroll into Plan 2, under the same Part D contract. How should this beneficiary be included in the MTM data?
   A: This depends on the level of reporting chosen by the Part D contract.
   If data are reported at the Contract level, this beneficiary should be counted once in data element A, number of beneficiaries who participated in the MTMP at any point during the specified time period. The beneficiary should not be counted in data element C, number of beneficiaries who disenrolled from the MTMP at any time during the specified time period.

   If data are reported at the Plan level, this beneficiary is reported separately by each Plan. Plan 1 would include this beneficiary in both data elements A and C. Plan 2 would report this beneficiary in data element A only.

3) For data element B, please clarify what is meant by "longitudinally cumulative total"?
   A: Data element B is the number of beneficiaries who participated in the MTMP at any point during the time period specified above, and should be a longitudinally cumulative total. This means that a Plan should report the number of beneficiaries who participated cumulatively at any time over the specific reporting period.

4) Does CMS want Plans to report total drug costs per MTMP beneficiary per month or only Part D covered drug costs?
   A: Plans should include only Part D covered drugs in this calculation.

5) If a MTM member leaves the plan for another plan or is terminated (e.g. moves out of service area, deceased) should the member be counted as a disenrolled MTM participant?
   A: Yes, a MTM participant who disenrolls from the Plan, or is deceased should be included in data element C, "beneficiaries who disenrolled from the MTMP".

6) Should Plans choosing to provide MTMP services to members outside of the CMS approved MTM criteria exclude those members' data from these reports?

A: Yes, these members should be excluded from this report, as these services are not considered by CMS as reimbursed MTM services.

Section V. Grievances

1) How are Plans expected to be able to report grievance data by Plan?
   A: Grievances under the Part D reporting requirements need to be reported at the Plan level. According to MMA, Plans must maintain grievance records containing at the minimum: date of receipt, final disposition of grievance, and date the enrollee was notified of the disposition. CMS expects that because Plans must record the date the enrollee was notified, Plans will collect identifying information for enrollees and will therefore be able to report grievance data by Plan.

2) Should complaints received by 1-800 Medicare be included in these grievance data?
   A: No. Plans should report data regarding grievances received directly by the Plans from beneficiaries.

3) Should Plans categorize grievances based on the subject as stated by the beneficiary, or based on the subject determined by the Plans during resolution? For example, a beneficiary may file a grievance alleging provider/pharmacy fraud. Upon investigation the Plan determines the beneficiary's grievance is related to privacy/confidentiality issues, and is not related to fraud.
   A: Plans may report grievances in the categories as determined by the Plans after initial investigation. In the example above, the Plan should report the grievance as a privacy/confidentiality grievance. Plans should not, however, dismiss or exclude any grievances filed by beneficiaries from this report.

Section VI. Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions

1) How will these data be released outside of CMS?
   A: CMS is reviewing the types of data that will be released. However, currently there are no plans to share Plan-submitted data related to coverage determinations and redeterminations as well as prior authorization and step therapy. These data will be used for monitoring and oversight purposes.

2) Does CMS want Plans to report data regarding quantity limits or non-formulary rejections?
   A: No, not for CY 2006.

3) For data element A, number of pharmacy transactions rejected due to failure to complete step therapy edit requirements in the time period specified above, and data element B, number of pharmacy transactions rejected due to need for prior authorization, should Plans report all transactions or only distinct drug claims?
   A: Plans should report the total number of pharmacy transactions. CMS understands these numbers may include multiple transactions for the same prescription drug claim.

Section VII. Appeals

1) Will Part D plan level exceptions and appeals data be made available to researchers?
   A: CMS anticipates public reporting of various Part D data metrics in the future. These metrics may include some Plan-reported data. At this time, CMS does not expect to release Plan specific data to researchers.

Section VIII. Call Center Measures

1) Please provide the CMS definition of Average Speed of Answer (element C).
   A: The Average Speed of Answer, as defined by CMS, is the average time from when a call enters the call center (e.g. from first "ring") until the call is first addressed by an automated call delivery system (ACD) or interactive voice recognition (IVR) welcome message if using an automated system or by an operator if not using an automated system (some call centers do not have ACD/IVR, and have live operators picking up the phones). For plans using an ACD/IVR system this is typically only a few seconds. Note the Average Speed of Answer defined by CMS in the 2006 Reporting Requirement document does not equate to the industry terms "average speed of answer" or "ASA".
2) Please provide the CMS definition of Average Hold Time (element E).
   A: CMS defines Average Hold Time as - *"time from entering a hold queue to being addressed by a customer service representative*" in the 2006 Part D Reporting Requirements document. To clarify, this time is measured *after* the caller exits the ACD/IVR system and *before* reaching the live customer service representative (CSR). Thus, time spent navigating an IVR/ACD by a caller is not included in the hold time. For calls where a live CSR directly answers the phone line, the hold time for these calls is zero. Note the Average Hold Time defined by CMS generally equates to the industry terms of "average speed of answer" or "ASA".
3) Can Average Time in Queue be reported for Average Hold Time? This is the average wait time that a caller spends waiting for a CSR to answer the telephone after being placed in the queue by the ACD/IVR. This includes only calls that actually had a wait time. This metric is also known as average time of delay.
   A: No. The Average Hold Time is calculated for all calls made to the call center and calls with a zero hold time must be included.
4) Can the Average Hold Time be while on the phone with a customer service representative *(this is the average amount of time that a caller is on hold after being connected to a customer service representative; this can be provided by most ACD or IVR systems)?*
   A: No. The Average Hold Time, as defined by CMS, is measured while on hold *before* reaching a live CSR. This *does not* include any time on hold after speaking to a CSR (e.g. does not include time on hold while the CSR researches an issue).
5) What specific element defined in the 2006 Part D Reporting Requirements is being used to determine if calls are being answered in a timely manner?
   A: The standard in the Part D 2006 application was to have 80% of calls to be answered in 30 seconds. For CY 2006, CMS is evaluating this standard by determining if 80% of calls have an answer speed (from element C) and a hold time (from element E) of less than 30 seconds. In other words, the time it takes for a call to be connected and reach any welcome message should be less than 30 seconds, and the time it takes for the call to enter a hold queue and reach a CSR should be less than 30 seconds. While we understand these labels may differ from industry

standards for call center metrics, CMS is using this approach in order to measure various points of customer service provided to Medicare beneficiaries.

6) For 2006, is there a requirement to report call center data from the pharmacy technical help desk in order to monitor operational standards?
A: At this point in time, there have been no changes to Section VIII - Call Center Measures in the 2006 Medicare Part D Reporting Requirements to include monitoring of the pharmacy technical help desk. (CY 2007 reporting requirements however will include this component.) Although Plans do not have to report on the pharmacy help line, they are still required to meet the standards put forth in the February 23, 2006 HPMS notification regarding pharmacy technical help desk wait times.

7) Are call center performance measures to be reported at a contract level (e.g. H or S number) or at a plan (PBP) level?
A: Regarding plan versus contract level reporting, provisions were granted for call center reporting to be at the contract level. Requiring more granular data would have a significant impact on existing call centers' systems.

8) What if beneficiaries call the same call center for Part D and non-Part D questions?
A: It is important to CMS that Part D calls be separated from other calls. Other than call abandonment, all data should be reported for Part D related calls only and should not include non-Part D related calls (e.g. medical benefit inquiries).

9) What if providers and beneficiaries call the same call center?
A: The purpose of this reporting requirement is to monitor customer service aspects related to the beneficiary call center that may impact the beneficiaries. If a Part D Sponsor's Call Center system allows for a separation of inbound Part D related beneficiary (enrollee, potential enrollee, or their representative), pharmacist, and/or physician/provider calls, the Sponsor should report data from the beneficiary calls only. However, if a Part D Sponsor's Call Center system does not allow for a separation of beneficiary, pharmacist, and/or physician/provider calls related to Part D, it will be acceptable to report all Part D related calls into the customer service line (i.e. combined beneficiary/pharmacist/physician). HPMS will allow Sponsors to indicate whether their call center system allows for separation of beneficiary and non-beneficiary calls.

10) How do Plans with multiple customer service lines report call center data?
A: The objective of this reporting requirement section is to evaluate customer service for the beneficiary. All customer service lines, whether for existing or prospective beneficiaries, should be summarized and included in Plans' reports to CMS.

11) For plans utilizing IVR systems, what is the correct way to report average speed of answer, as the IVR provides a nearly instantaneous connection to the plans' welcome message.
A: In this case, the average speed of answer should be reported as 00:01 as it is the smallest unit of time available for entry into HPMS.

Section IX. Overpayment

1) What does CMS consider an overpayment?

   A: An overpayment occurs anytime Medicare directly, or through one of its contractors, erroneously makes a payment. The actual overpayment amount is the amount of money received in excess of the amount due and payable under the Part D drug benefit. Examples would include overpayments made to pharmacies, overpayments a Plan makes to a PBM for claims payment, and findings from pharmacy audits. This means any funds the plan recovers from any entity it has overpaid. The term overpayment does not include premium overpayments. This information is necessary to ensure that overpayments are being identified and recouped appropriately. This will assist CMS in Part D Plan payment reconciliation of a plans' allowable incurred reinsurance costs for the year with the year's prospective plan payments; CMS will then reimburse plans for any underestimation of costs or recover any agency overpayments.

2) Regarding data element B, the total overpayment dollars recouped by the Plan, is this a running total of dollars recouped from one six month period to the next? One example given: $1,000 has been recovered for the 1/1/06 - 6/30/06 pharmacy audit by the 8/31/06 report date. Another $500 is recovered from the same period is brought in after 8/31/06. Where should the additional $500 be reported?
   A: A and B are not rolling YTD amounts, but amounts that are specific to the reporting period. If funds are recouped in 2nd period that were identified in 1st period, plan is to report as data element B in 2nd period.

3) Is an incorrect administrative fee one example of an overpayment that should be reported?
   A: Yes. If the plan feels there were payment errors made relating to any types of administrative fees, these should be included in the plan's report to CMS. This section is intended to capture any payment errors that a Plan feels have occurred during each reporting period.

4) Are claim reversals or adjustments considered overpayments?
   A: Plans have already reported this information in the Reversals reporting section, and should not include these data in the Overpayments section.

5) Should payment errors relating to beneficiary payments, specifically relating to LIS beneficiaries, be reported as overpayments?
   A: No, as CMS has not made a policy decision regarding beneficiary liability generally or related to LIS determinations, at this time Plans should not include money related to beneficiary liability and debt collection.

6) How should a Plan indicate to CMS that there were no overpayments identified during a reporting period?

A: A Plan should enter 0 in each field of the overpayment reporting section to reflect no overpayments were identified. It is incorrect to select the box “No Data to Report”.

Section X. Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions

1) Does Part D require that a drug manufacturer be a participant in the rebate program for a Plan to cover the manufacturer's drug?
   A: No, MMA does not require Part D plans to operate under such restrictions when determining formulary inclusion of a drug.

2) As of 5/2006, this section is not displayed in HPMS.
   A: Data for this reporting section are not due until 9/30/06, and therefore this HPMS section has not been released yet. Plans will receive notification when this section has been released.

3) What is the correct level of rebate reporting?
   A: Plan Sponsors with multiple "H" numbers can submit one report for the group of H numbers. Alternatively, one report for each H number can also be submitted.

4) In what format should these data be submitted?
   A: These data should be provided in a Microsoft Excel file, and uploaded into HPMS. The following file format should be used:

   Rebate information:

Manufacturer Name	Drug Name	Rebates Received	Pending Rebates	Prior Rebates
Text	Text	Currency	Currency	Currency

   Discounts and other Price concessions:

Manufacturer/Company Name	Description	Value	Justification
Text	Text	Currency	Text

5) Should Part D plan sponsors include grant money received from a pharmaceutical manufacturer in the Discounts and other Price concessions file? Some grant money may be received by sections of an organization not directly administering the Part D benefit.
   A: Plans should report any grant monies that are related to Part D business, regardless of the formal recipient in the organization.

6) In the Pending Rebate field, are Plans to reflect the pending rebates for the specified reporting period only, or include all pending rebates YTD?
   A: Rebates are to be reported on a quarterly basis, not as a cumulative total. Therefore only those rebates identified to be pending during the specific quarter should be reported for that quarter, and should not be carried forward. For example, in Quarter 1 a plan identifies $100 in pending rebates. The plan reports this value in Q1 report. In Quarter 2, the plan determines those $100 remain outstanding, but the plan should not carry the pending $100 to Q2's pending rebates report.

7) How should short paying by the manufacturer be accounted? Plans may not ultimately be paid by the manufacturer for the full rebate amount. In the Pending Rebate field, should Plans reflect the amount shorted as well as what has been billed but not paid?
A: These reports are not cumulative, but quarterly snapshots. Plans should account for short pays, as well as overpays. Here are 2 scenarios that demonstrate how data should be entered:

Short pay: In this scenario, it is determined in Q2 that a Plan has only received $50, and will not receive the remaining $50 as reported in Q1. To account for this, the Plan should enter the difference as a negative value in the pending rebate column: (-$50), and the amount received in the prior rebates column.

	Manufacturer Name	Drug Name	Rebates Received	Pending Rebates	Prior Rebates
Q1	Manuf A	Drug B	0	100	0
Q2	Manuf A	Drug B	0	-50	50

Overpay: In this scenario, it is determined in Q2 that a Plan received more than the full pending amount reported in Q1, $200. To account for this, the Plan should enter the difference as an additional value in the pending rebate column: ($50). The Plan will also enter the total rebates received for the prior quarter Q1, $250.

	Manufacturer Name	Drug Name	Rebates Received	Pending Rebates	Prior Rebates
Q1	Manuf A	Drug B	0	200	0
Q2	Manuf A	Drug B	0	50	250

8) Should various formulations of one drug be reported as separate rebate records? Example – Zocor 10 mg tablet, Zocor 20 mg tablet, Zocor 40 mg tablet.
A: Please rollup formulations of the same drug to one record in the rebate file. In this example, Zocor would be inputted as the drug name, along with the total rebate amounts for all Zocor formulations.

Section XI. Licensure and Solvency, Business Transactions and Financial Requirements

1) Does this section apply to all Part D plans?
   A: These requirements apply only to PDP organizations. Other organizations will not see this section displayed in HPMS. Data are to be entered at the contract level.

2) Will CMS accept the corresponding LAH (Life and A&H) Blank pages in lieu of Health Blank pages?
   A: Yes.

3) When reporting on claims paid, should Plans report only those they have received Medicare payment, or also include those claims they are working through the reconciliation process?
   A: Plans should report for both types of claims.

4) What is meant by licensed or non-licensed Part D sponsor?
   A: A licensed PDP sponsor refers to one that is licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in at least one state.

5) What if our organization is licensed in some states, but not all states in which we operate?
   A: Contracting entities licensed in at least one state as a risk-bearing entity would be required to meet Part D reporting Requirements for licensed PDP sponsors.

6) Is there a contact name to put on documents mailed to CMS?
   A: The L&S contact person is Robert Ahern, robert.ahern@cms.hhs.gov.

7) Would electronic filings (PDF files) meet filing requirements, or are only hard copies acceptable?
   A: The requirements indicate that hard copies should be mailed.

8) Are there any special requirements for the Actuarial Opinion to address specific to the Medicare Part D reporting requirements?
   A: There is nothing specific to the Part D reporting requirements. Actuarial opinions should address the assumptions and methods used in determining loss reserves, actuarial liabilities and related items.

9) What constitutes a management letter?
   A: A statement made by an organizations independent auditor addressing internal controls and other management issues discovered during the audit. It usually covers areas needing improvement and recommendations for addressing those areas.

10) Is a letter of deficiencies from the auditor required in all cases?
A: No

11) Were administrative expenses to be shown net of (offset by) ASO revenue as is statutory procedure?
A: Yes

12) Does CMS plan on making the financial information under Section XI “public information” after reporting?
A: No, not at this time.